STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155698	A. BUII B. WIN			06/30/2	2011
	PROVIDER OR SUPPLIER			1707 BI	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	State Licensure S Survey Dates: Jr 2011 Facility Number Provider Numbe AIM Number: 0 Survey Team: Tammy Alley RN Toni Maley BSW Donna M. Smith	une 27, 28, 29, and 30, : 011045 r: 155698 08110451 N TC V RN I (June 27, 28 and 29, e:	FO	0000	Submission of this Plan of Correction does not constitute admission by Bethany Point Health Campus of any wrondoing or failure to comply we Federal or State Regulation Moreover, the allegations contained in this statement deficiencies are not a true of accurate portrayal of the proof nursing care or the service this facility. This provider we this plan of correction be considered as our allegation compliance. The provider respectfully requests a destreview with paper compliant considered in establishing the provider is in substantial compliance.	te ng ith s. of or ovision ces of ishes n of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WF4S11 Facility ID: 011045

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/30/2	LETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD					
BETHAN	Y POINTE HEALTH	I CAMPUS		ANDER	SON, IN46012			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	These deficienci	es also reflect state accordance with 410 IAC ompleted 7/6/11		TAG	DEFICIENCY		DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DITT	DDIC	00	COMPL	ETED
		155698	A. BUILI			06/30/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
DETLIAN	V DOINTE LIEALTH	LCAMPLIE			ETHANY RD SON, IN46012		
BETHAN	Y POINTE HEALTH	I CAMPUS		ANDER	SON, 11146012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	•	nediately inform the					
SS=E		vith the resident's physician;					
		y the resident's legal					
		an interested family member					
		accident involving the					
		ults in injury and has the					
		ing physician intervention; a in the resident's physical,					
	•	social status (i.e., a					
	deterioration in he						
		is in either life threatening					
		cal complications); a need to					
	alter treatment sig	nificantly (i.e., a need to					
	discontinue an exi	sting form of treatment due					
		quences, or to commence a					
		nent); or a decision to					
		ge the resident from the					
	facility as specified	d in §483.12(a).					
	The facility must a	Iso promptly notify the					
	-	own, the resident's legal					
		nterested family member					
	-	lange in room or roommate					
		ecified in §483.15(e)(2); or					
		ent rights under Federal or					
	State law or regula	ations as specified in					
	paragraph (b)(1)	of this section.					
	•	ecord and periodically					
		s and phone number of the					
		presentative or interested					
	family member.		E01		Corrective actions		07/20/2011
		review and interview,	F01	13/	accomplished for those resid	ents	07/30/2011
	-	to notify the physician			found to have been affected		
	when a resident's	s condition changed in a			the alleged deficient practice		
	manner that migh	ht require a change in			Resident #52 and #44 record		
	_	sident with abnormal			reviewed to ensure MD		
	· ·	idents who had emesis			notification is in place for any	high	
	(vomiting), resid				/ low blood sugar readings pe	er	
					MD ordered parameters.		
	medications held	for low blood pressures			Resident #16 record reviewe	d to	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		ONSTRUCTION 00	(X3) DATE SU COMPLE	
		155698	A. BUII B. WIN			06/30/20	11
	PROVIDER OR SUPPLIER			1707 BI	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD RSON, IN46012		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	nlass	DATE
	for 4 of 15 reside				ensure MD notification is in for any noted episodes of	place	
	* *	ation when indicated in a			emesis. Resident #54 reco	rd	
	` `	esidents #52, #44, #54 &			reviewed to ensure MD is n	otified	
	#16)				prior to holding any medical		
	Findings include	:			Identification of other reside having the potential to be a by the same alleged deficie	fected	
	· /	's record was reviewed			practice and corrective action taken: Record review for page 1	ast 7	
	on 6/27/11 at 10:45 a.m.				days of residents with accur orders to ensure MD notific		
	Resident #52's current diagnoses included, but were not limited to, diabetes mellitus,				for high / low readings per	:•	
					parameters is documented, indicated. 24 hour report re		
	hypertension.	,			for past 7 days for any		
					documented episodes of en	nesis.	
	 Resident #52 wa	s admitted to the facility			If indicated, will review resid	lent's	
		dent #52 had current,			record to ensure MD was notified. Medication		
	6/15/11, physicia	· ·			administration record review	y for	
	o/15/11, physicia	in solucis for.			past 7 days for resident's		
	a) agguahaaka	(blood sugar checks)			receiving antihypertensive		
	· ·	before lunch, before			medications to ensure MD v		
	· · · · · · · · · · · · · · · · · · ·	*			notified if medication was he		
	supper and at bed	itime.			Measures put into place and systemic changes made to	1	
					ensure the alleged deficient		
	' ' '	ysician if the resident's			practice does not recur: DF	IS or	
	_	lts was less than 60 or			designee will review campu	s	
	greater than 400.				guidelines for physician notification with licensed nu	raaa	
					The Medication Administrat		
		dent #52's accucheck			Record will be changed in the		
		ng notes indicated the			diabetic orders will now app	ear on	
	_	nts of low blood sugar			different colored paper and		
		was not notified as			order for MD notification pe parameters will be listed wit		
	follows:				accucheck order. Diabetic		
	a.) 6/16/11 before	re breakfast a result of 52.			will be listed on the same pa		
	b.) 6/16/11 before	re supper a result of 44.			for licensed nurses to initial		
	c.) 6/18/11 before	re supper a result of 49.			How the corrective action w	ill be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET	
		155698	B. WIN			06/30/201	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RETHAN	Y POINTE HEALTH	CAMPLIS		1	ETHANY RD SON, IN46012		
					.3011, 11140012		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE (DATE
		re breakfast a result of			monitored to ensure the alleg	ned	2.112
	50.	re oreakiast a result of			deficient practice does not re	· .	
		re supper a result of 51.			Medical Records or designed	e will	
	(c.) 0/22/11 0C101	te supper a result of 31.			audit the medication administration records for MI	,	
	2.) During a 6/29	9/11 1:40 n m			notification of high / low bloo		
	, .	rector of Nursing			sugar readings per MD order		
	· ·	ility did not have any			parameters. Audit will be		
		r additional information			completed daily x 2 weeks, tweekly x 2 weeks, then mon		
	to provided regar				until substantial compliance		
		ck there of regarding the			obtained. DHS or designee		
	above low blood	• •			audit for completed change i	n	
	above low blood	ouguro.			condition forms with MD notification related to episode	as of	
					emesis and holding of	3 01	
					medications. Audits will be		
					completed daily x 2 weeks, t		
					weekly x 2 weeks, then mon- until substantial compliance		
					obtained. The results of the	•	
					audits will be presented to th	e	
					Quality Assurance Committe		
					a monthly basis until consisted application of the guidelines		
					noted. Periodic evaluation w		
					conducted for following appli		
					guidelines.		
		r Resident # 44 was					
	reviewed on 6/29	9/11 at 10 a.m.					
	_	es included, but were not					
	limited to, Diabe	tes.					
	,	0. 1. 0011111111111					
	-	for June 2011 indicated					
		s to be notified of blood					
	-	than 70 and greater than					
	400. Original da	te of order was 7/23/10.					

011045

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S		
		155698	B. WIN			06/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE	<u>Į</u>	
				1	ETHANY RD		
BETHAN	Y POINTE HEALTH	CAMPUS		ANDER	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
IAG		LSC IDENTIFYING INFORMATION) Administration Record	_	TAG	DEFICIENCE!)		DATE
		nd June 2011 indicated					
		ood sugar results and the					
	_	ysician notification of the					
	high blood sugar	-					
	ingii olood sugal	. .					
	April 1 at supper	blood sugar was 424.					
		r blood sugar was 425.					
		r blood sugar was 455.					
		r blood sugar was 422.					
	* *	r blood sugar was 462.					
	* *	r blood sugar was 497.					
		r blood sugar was 418.					
	On 6/29/11 at 9:3	30 a.m., additional					
	information was	requested from the					
	Assistant Directo	or of Nursing regarding					
	lack of physician	notification of the high					
	blood sugars.						
	On 6/29/11 at 2:	-					
	-	sistant Director of					
	_	d the physician was not					
	notified of the hi	gh blood sugars.					
	4 Resident #16'	s record was reviewed on					
		.m. The resident's					
		ed, but were not limited					
	_	mentia, and left sided					
		e quarterly minimum data					
	-	ated 4/22/11, indicated					
		e poor decisions requiring					
	and restricting illaut	c poor accisions requiring					

011045

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE : COMPL		
		155698	B. WIN			06/30/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD		
BETHAN	Y POINTE HEALTH	CAMPUS		ANDER	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		e resident had a feeding		IAG			DATE
	tube.	resident had a recalling					
	tube feeding of C	der, dated 1/28/11, was a Osmolite 1.5 at 45 ur for 12 hours and was 7:00 p.m. to 7:00 a.m.					
		ecap orders, signed and as a pureed diet with ds.					
	5:30 p.m., indica large amount of e 100% of food aft member. She ha had vomited. Sh much better after	indicated concerning the					
	exit conference, i	30 p.m. during the daily information was ning the lack of physician ed to Resident #16's					
		rector of Nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		(X2) MU A. BUILI B. WING	DING	nstruction 00	(X3) DATE S COMPL 06/30/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE		
BETHAN	IY POINTE HEALTH	I CAMPUS		ANDER	SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	6/27/11 at 3:35 p diagnoses include to, cerebrovascu (stroke), debility The physician of Amlodipine (No 1 tablet by mouth hypertension. The physician of Carvedilol (Corectimes a day for her The "NURSE'S 16:00 p.m., was the tired. Her blood The medications were held due to The nurse's notes concerning physical to the held medical On 6/29/11 at 2:12 exit conference, requested concernotification related blood pressure in On 6/30/11 at 8:13 interview, the Distinction of the held medical concernotification related blood pressure in the property of the held medical concernotification related blood pressure in the property of the held medical concernotification related blood pressure in the property of the propert	NOTES," dated 3/30/11 at the resident was awake but pressure was 103/53. Norvasc and Coreg, a low blood pressure. Is lacked information ician notification related cations. 30 p.m. during the daily information was raing lack of physician ted to Resident #54's held medications.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155698	A. BUILDING B. WING		06/30/2		
	PROVIDER OR SUPPLIER Y POINTE HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN46012				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	'RIATE	DATE	
	concerning Resid	lent #54's held blood ions.					
	GUIDELINES" g by the Director o	CIAN NOTIFICATION guidelines was provided f Nursing on 6/29/11 at urrent policy indicated					
	"Purpose:						
	of all diagnostic to in condition in a evaluate condition	ident's physician is aware testing results or change timely manner to n for need of provision terventions for care"					
	3.1-5(a)(3)						
F0221 SS=D	physical restraints discipline or conve treat the resident's Based on observa interviews, the fa resident was able restraint concerni (Resident #51) ar recliner (Residen	the right to be free from any imposed for purposes of enience, and not required to a medical symptoms. ations, record review, and acility failed to ensure a to move freely without ting a self-releasing belt and positioning in a t #6) for 2 of 4 residents estraints in a sample of 15.	F0221	#1 Corrective actions accomplished for those re found to have been affect the alleged deficient practice. Resident #51 was assess the Interdisciplinary Team release alarming belt was discontinued. Implement personal clip alarm to ale	ed by ice: ed by . Self ed	07/30/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155698	B. WIN			06/30/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ETHANY RD		
RETHΔN	IY POINTE HEALTH	I CAMPUS			SON, IN46012		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
					unassisted transfers. Resid	ient	
	Findings include	»:			basket were removed from the		
					area. Recliner was found to		
	1. On 6/27/11 at	t 11:30 a.m., Resident #51			defective in that the foot rest		
	was observed in	her wheelchair with her			would not stay up in the prop		
		arm belt on. When LPN			position.#2 - Identification of		
		resident to remove her			other residents having the		
	1 ^				potential to be affected by the		
	1	arm belt several times, the			same alleged deficient practi	ce	
		erved to touch her belt			and corrective actions taken: Residents with enable	ire .	
		eral times, and then, she			observed to ensure they wer	-	
	said, "no." LPN	#3 indicated she was not			able to release their enabler		
	able to release th	ne belt now.			command. If unable, the res		
					will be assessed for reductio		
	Resident #51's re	ecord was reviewed on			device or coded as restraint	if a	
		o.m. The resident's			reduction is not indicated. N		
	_	led, but were not limited			other defective recliners are		
					campus.#3 - Measures put i	nto	
	to, Alzheimer's o				place and systemic changes made to ensure the alleged		
	hallucinations/de	elusions.			deficient practice does not re	cur.	
					DHS or designee will in-serv		
	The physician's	order, originally dated			nursing staff on the campus		
	4/11/10, was self	f-releasing seat belt as an			guidelines for Restraint / Ena	ıbler	
	enabler to wheel	chair to alert staff to			use. Residents with self		
	attempts at unass	sisted ambulation. The			releasing seat belts will be a		
	_	e to remove belt on			to release their belts every sl		
	command.	e to remove beit on			and will be documented on the medication administration re-		
	Command.				The interdisciplinary team wi		
	TI HOME LED	NHIDODIO			continue to assess all restrai		
	The "SKILLED				enablers routinely per campu		
	ASSESSMENT				guidelines#4 - How the corre		
		" dated 5/26/11, indicated			measures will be monitored t	ю	
	the resident's cognitive patterns was				ensure the alleged deficient	, l	
	"periods of confi	usion at times." The			practice does not recur: DHS		
	"Safety and mobility" section indicated no				designee will audit medication administration documentation		
		cerning the resident's			every shift requesting reside		
	self-releasing ala				demonstrate ability to release		
	sem-remeasing all	mm UCIL.	1		1		

011045

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155698	A. BUII		00	06/30/2	
		100000	B. WIN		DDDEGG GETY GTATE ZID GODE	00/00/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ETHANY RD		
BETHAN	IY POINTE HEALTH	CAMPUS		1	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	INTERVENTION indicated this was the belt alarm. The RE-ASSESSME device was not control but as an enabler the resident from could previously restrict movement remove the device the "IDT (Interding REVIEW" section 3/21/11, indicated assessment. The awareness conting frequently. 2. On 6/27/11 at was observed in The foot of the reby a wastebasket on 6/27/11 at 3:0 interview, LPN # wastebasket was feet up higher. A indicated the was considered a rest	CE, ASSESSMENT AND N," dated 3/16/11, s a quarterly review for the "RESTRAINT RISK NT" section indicated the considered as a restraint due to it did not prevent doing something they do and/or it did not and/or the resident can be upon request. Also, sciplinary team) on, which was dated do to continue alarms per resident's safety nued to be an issue			seat belt on command. This will occur daily x 2 weeks, when monthly untisubstantial compliance is me The defective recliner has be discarded. Results of the aud will be presented to the Qual Assurance Committee on a monthly basis until consisten application of the guidelines noted. Periodic evaluation where conducted for following applit guidelines.	eekly I t. een its ity t are	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155698	B. WIN			06/30/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIE	₹		1	ETHANY RD		
BETHAN	IY POINTE HEALTH	H CAMPUS		1	RSON, IN46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	On 6/28/11 at 3:	30 p.m., Resident #6 was					
	observed in the TV area by the nurse's station sitting in a recliner. The foot of						
	the recliner was	being held up by a					
	wastebasket.						
	Resident #6's rea	cord was reviewed on				l	
		a.m. The resident's					
		led, but were not limited				l	
	~						
	to, organic brain	-					
		The quarterly minimum					
		ent, dated 5/10/11,					
		ident made poor decisions					
	requiring superv	rision.					
	3. The "GUIDE	I INES EOD					
		NABLER USE" policy					
		the Director of Nursing					
		30 a.m. This current					
	policy indicated	the following:					
	"Purpose:						
	1 ^	letion of assessment and					
	_					l	
	1	ppropriate and safe use of					
	restraints.						
	Procedure:						
		ination of whether a				l	
		ot a restraint is based on				l	
		d, assessment of the				l	
		sessment identifies the				l	
						l	
		symptom and evaluates				l	
		nefits and the purpose				l	
	being considered	d for the use of a device or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	
		155698	B. WIN			06/30/2	011
	PROVIDER OR SUPPLIER			1707 BE	DDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	whether the residindependently rewhether the device freedom of move these questions windividual resides8. Consideration whether the device enabler: a. If the device of resident from doing previously do AM function to a high ENABLER, NOT b. If a device resident from gomething BUT allows a resident from the configuration of the protocol must be c. If a device resident from the protocol must	moving the device and ce restricts the resident's ement. The answers to will vary with the int situation. One for determining ce is a restraint or an aloes NOT restrict the ing something they could ND assists the resident's increase her level, it is an a restraint. Stricts the resident from they could previously do sident to function at a an enabler AND a case the restraint followed. The tricts the resident from they could previously do sist the resident from they could previously do sist the resident to mer level, it is a restraint to mer level, it is a restraint					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED	
		155698	B. WIN			06/30/2	011	
			D. WIIV		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			l	ETHANY RD			
	Y POINTE HEALTH	I CAMPUS		l	SON, IN46012			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION FACH CORRECTIVE ACTION SHOULD BE			(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0223 SS=D	verbal, sexual, phy	he right to be free from ysical, and mental abuse, ent, and involuntary						
	The facility must in sexual, or physical punishment, or invition Based on record facility failed to a from verbal abust reviewed for alles sample of 15. (Resident # 47's december 6/26/11 sometime into the facility and he was sitting lounge. As she was she heard LPN # from the nurses shis wheelchair are indicated she felt her father because were sending him indicated QMA # yelling at her dates she had spoke with 11 on that day and	roluntary seclusion. review and interview, the ensure a resident was free the for 1 of 1 resident regations of abuse in a desident # 47)	FO	223	#1 Corrective actions accomplished for those reside found to have been affected the alleged deficient practice investigation was initiated on 6/26/11. The Administrator wontified of the allegation of all on 6/28/11. The employee work suspended on 6/28/11 pendiction investigation and the initial rewassent to the ISDH via fax 6/27/11. The investigation work completed and the allegation abuse was unsubstantiated related to the the employee on thave the willful intent to it mental anguish to this reside. The employee raised her voit the resident, who was across room, in an effort to prevent from falling due to he was attempting to stand up from the wheelchair. The employee returned to work with counse regarding customer service at 1:1 inservicing on campus guidelines for abuse, stress aburnout, and appropriate way communicate with residents are hard of hearing. A follow report was sent to the ISDH of the street of the street of the ISDH of the	by: The: : The vas ouse vas ng eport on as of did inflict nt. ce to the him nis eling and ys to who yup	07/30/2011	
	filled out a form.				fax. #2 - Identification of oth residents having the potential be affected by the same alleg	ier Il to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155698	B. WIN			06/30/2	011
	PROVIDER OR SUPPLIER		!	1707 BE	DDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
	Review of a "Redated 6/26/11 at # 11 indicated the came in to see the returned from the the SW that she syelling at her fathad heard this nustatements in the mumble under he for her father. The nurse would tone in front of pwhen no one was A written form deprovided by the 6/30/11 at 8:40 at typed paper sign indicated she had 6/26/11 and the she heard LPN # resident to stop a indicated she fell with the resident had spoken to the indicated she had because the resident resident resident resident to stop a indicated she had spoken to the indicated she had because the resident	ETATEMENT OF DEFICIENCIES (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) sident Concern Form" 1 p.m., completed by SW e resident's daughter had he SW after her father had he hospital. She informed had heard LPN # 10 her. She indicated she herse make derogatory he past and had heard her hear breath when caring he daughter indicated if he speak to a resident in that he people, what might she do had saround. Atted 6/26/11 was Director of Nursing on he daughter indicated if he speak to a resident in that he people, what might she do he saround. Atted 6/26/11 was Director of Nursing on he day he SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he spoken to QMA # 9 on he can be supplied by the SW. The form he down. She further he the LPN was "harsh" he can be supplied by the SW. The form he down she further he the LPN was "harsh" he form indicated she he LPN # 10 and the LPN he donly raised her voice he the SW to start a		1707 BE	ETHANY RD	tive ave y this - S or e - s will es will ll be ekly s to dits eer.	(X5) COMPLETION DATE
On 6/28/11 at 9 a.m. during interview,							
	On 6/28/11 at 9 a	a.m. during interview,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	IBER:	A. BUIL	DING	00		COMPL	
		155698		B. WING	3 <u> </u>			06/30/2	U11
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>			ADDRESS, CITY, STA	ATE, ZIP CODE		
						ETHANY RD			
BETHAN	Y POINTE HEALTH	CAMPUS			ANDER	SON, IN46012			
(X4) ID		TATEMENT OF DEFICIE			ID		PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDE			PREFIX	CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INF			TAG	DEF	TCIENCT)		DATE
	`	ed that on 6/26/11							
		10 "screaming" a							
	resident. She indicated she felt the nurse								
	was very inappropriate and if had of been								
	her family she would have been upset.								
	On 6/28/11 at 9:50 a m. during interview								
On 6/28/11 at 9:50 a.m., during interview,									
	the Administrator indicated he had not								
		f the above allega	tion of						
	verbal abuse.								
	6/20/11 + 10	10 1 :							
	on 6/28/11 at 10:	_							
	·	rector of Nursing							
		l been informed o							
		$\frac{1}{26/11}$ by the Soc							
		icated she had inf							
		investigate the ev							
		e did not consider							
		She indicated she							
	·	e nurse is hard of	•						
		esident. She indic							
		it potential abuse.	. She						
	indicated she had								
		d LPN # 10 had r							
	-	nd not worked sine	ce the						
	event.								
	On 6/28/11 at 10								
		rector of Nursing							
		10 had been susp							
		ation. She indicat							
		wed everyone inv							
	in the above ever	nt and the investig	gation						
	was ongoing.								
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete	Event ID:	WF4S11	Facility l	ID: 011045	If continuation sh	eet Pa	ge 16 of 63

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	C	X3) DATE S COMPLI	ETED
		155698	B. WIN	G			06/30/20	011
	PROVIDER OR SUPPLIER		'	1707 BE	DDRESS, CITY, STAT ETHANY RD SON, IN46012	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE JENCY)	=	(X5) COMPLETION DATE
	Procedural Guid the Administrator and deemed as condicated: "Purp implemented processure the preventage of alles and deemed of alles are suspected or alles are less are the preventage of the p	tion:Suspend suspected ding outcome of ne Executive Director is						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	WF4S11	Facility I	D: 011045	If continuation she	eet Pag	je 17 of 63

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155698	B. WING		06/30/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	L		ETHANY RD			
BETHAN	Y POINTE HEALTH	I CAMPUS		RSON, IN46012			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL			TE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0225 SS=D	have been found of or mistreating resistance had a finding nurse aide registry mistreatment of resistreatment of their property; a has of actions by a employee, which we service as a nurse	and temploy individuals who guilty of abusing, neglecting, dents by a court of law; or a gentered into the State of concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for a aide or other facility staff to de registry or licensing					
	The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).						
	alleged violations	nave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the adding representative and accordance with Sistate survey and working days of the	nivestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 to incident, and if the alleged d appropriate corrective sen.					
	Based on record facility failed to verbal abuse was and reported the	review and interview, the ensure an allegation of a thoroughly investigated appropriate agencies resident reviewed for	F0225	#1 Corrective actions accomplished for those resic found to have been affected the alleged deficient practice investigation was initiated or 6/26/11. The Administrator v	by e: The		

011045

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPL	ETED	
		155698	B. WIN	LDING		06/30/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEI	R		1	ETHANY RD			
DETUAL	IY POINTE HEALTH	L CAMPILIS		1	RSON, IN46012			
	T FOINTE HEALT	T CAMP 03		ANDER				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION	
TAG	†	R LSC IDENTIFYING INFORMATION)	+	TAG			DATE	
	"	erbal abuse in a sample of			notified of the allegation of a			
	15. (Resident #	47)			on 6/28/11. The employee value on 6/28/11 pend			
					investigation and the initial r			
	Findings include	e:			was sent to the ISDH via fax			
	I manigo merade.				6/27/11. The investigation v			
	On 6/27/11 at 8:	45 a.m., during interview,			completed and the allegation	n of		
	1	daughter indicated on			abuse was			
		ne after lunch she came			unsubstantiated related to the			
					employee did not have the v			
	1	after her father had fallen			intent to inflict mental anguis this resident. The employee			
	1	ng in his wheelchair in the			raised her voice to the	7		
	lounge. As she	walked up the hallway,			resident, who was across the	<u> </u>		
	she heard LPN #	† 10 yelling at her father			room, in an effort to prevent			
	from the nurses	station to get back into			from falling due to he was			
	his wheelchair a	nd to sit down. She			attempting to stand up from	his		
		t the nurse was "mad" at			wheelchair. The employee			
		se he had fallen and they			returned to work with counse			
		m to the hospital. She			regarding customer service 1:1 inservicing on campus	anu		
	"	•			guidelines for abuse, stress	and		
	`	# 9 had heard LPN # 10			burnout, and appropriate wa			
	1 -	d. The daughter indicated			communicate with residents	who		
	1 *	rith Social Worker (SW) #			are hard of hearing. A follow	-		
	I -	nd informed her of the			report was sent via fax to the			
	situation and she	e indicated the SW had			ISDH#2 - Identification of of			
	filled out a form				residents having the potention be affected by the same alle			
					deficient practice and correct			
	Review of a "Re	esident Concern Form"			actions taken:All residents h			
		1 p.m., completed by SW			the potential to be affected b	y this		
		ne resident's daughter had			alleged deficient practice.#3			
	1	ne SW after her father had			Measures put into place and	I		
					systemic changes made to ensure the alleged deficient			
	1	e hospital. She informed			practice does not recur: DH			
		had heard LPN # 10			designee will review campus			
		ther. She indicated she			guidelines with staff for Abus			
	had heard this nurse make derogatory				and Neglect Procedures. #4			
	statements in the	e past and had heard her			How the corrective measure	s will		
	mumble under h	ear breath when caring			be monitored to ensure the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		(X2) MULTI A. BUILDIN		OO	(X3) DATE S COMPLI	ETED	
		155698	B. WING			06/30/20)11
	PROVIDER OR SUPPLIER		17	707 BE	DDRESS, CITY, STATE, ZIP CODE THANY RD SON, IN46012		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	II PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	(X5) COMPLETION
PREFIX TAG	for her father. The nurse would stone in front of p when no one was A written form deprovided by the I 6/30/11 at 8:40 a typed paper signal indicated she had 6/26/11 and the C she heard LPN # resident to stop a indicated she felt with the resident had spoken to the indicated she had because the resident had she informed grievance proces investigate in the On 6/28/11 at 9 a QMA # 9 indicated had heard LPN # resident. She indicated the was very inapproper family she were the Administrator.	ne daughter indicated if speak to a resident in that eople, what might she do around. ated 6/26/11 was Director of Nursing on .m. The form was a ed by the SW. The form I spoken to QMA # 9 on QMA had informed her 10 "yelling" at the nd sit down. She further the LPN was "harsh" The form indicated she et LPN # 10 and the LPN I only raised her voice ent was hard of hearing. Nursing was informed I the SW to start a sand she would		FIX AG	alleged deficient practice does not recur: DHS or designee we conduct resident interviews regarding staff treatment of residents. The interviews will completed on 3 residents we times 4 weeks, then 3 residents monthly x 5 months ensure compliance. The auwill then be conducted randomly as needed thereaft. The results of the resident interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee a minimum of 6 months, ther randomly thereafter.	es vill Il be ekly s to dits er.	COMPLETION DATE

		X1) PROVIDER/SUPPLIER/CLIA	(X	2) MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	BUILDING	00		COMPL	
		155698	В.	WING			06/30/2	U11
NAME OF F	PROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
				I	ETHANY RD			
BETHAN	Y POINTE HEALTH	I CAMPUS		ANDEF	RSON, IN46012			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FU		PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIATI	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	ON)	TAG	DEF	ICIENCY)		DATE
	6/00/11	10 1 :						
	on 6/28/11 at 10:							
	•	rector of Nursing						
	indicated she had been informed of the							
	above event on 6/26/11 by the Social							
	Worker. She indicated she had informed							
the SW to try to investigate the event.								
She indicated she did not consider this to								
be verbal abuse. She indicated she knows			'S					
the nurse, and the nurse is hard of hearing			g					
and so was the resident. She indicated she			ne					
	did not consider it potential abuse. She							
	indicated she had	l not notified the						
	Administrator an	d LPN # 10 had not bee	n					
	suspended but ha	nd not worked since the						
	event.							
	On 6/28/11 at 10	:50 a.m., during						
		rector of Nursing						
	·	10 had now been						
		ng investigation. She						
		I now interviewed						
		ed in the above event and	d					
		was ongoing. This was	I .					
		e alleged event of verba	I .					
	abuse.	c anegeu event or verba	1					
	avust.							
	A favad Incident	Report form dated and						
		-						
		3:07 p.m., provided by						
		fursing on 6/29/11 at 2:3						
	_	ne allegation of verbal						
		eported to the Indiana						
	State Department of Health. This was 2							
	days after the eve	ent.						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event	ID: WF4	S11 Facility	ID: 011045	If continuation sh	eet Pa	ge 21 of 63

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155698	B. WIN			06/30/2	011
	PROVIDER OR SUPPLIER Y POINTE HEALTH		_ !	1707 BE	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Procedural Guide the Administrator and deemed as cuindicated: "Purpimplemented programment of the preventage of the preventage of their age, ability disability The slimanager is identification of the Executive Direct Notification of Sidealth and other agencies Protect employee(s) pendicated: "Purpimplemented process, as follows: "Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other agencies Protect of the Executive Direct Notification of Sidealth and other notification of Sidealth and other notification of Sidealth and other n	fied as responsible for continuing the reporting vs:immediately notify rectorcompleted ident ReportThe or is responsible for: 1. tate Department of r tion:Suspend suspected ding outcome of ne Executive Director is					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155698 06/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1707 BETHANY RD BETHANY POINTE HEALTH CAMPUS ANDERSON, IN46012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must develop and implement F0226 written policies and procedures that prohibit SS=D mistreatment, neglect, and abuse of residents and misappropriation of resident property. #1 Corrective actions Based on record review and interview, the F0226 07/30/2011 accomplished for those residents facility failed to implement their abuse found to have been affected by policy by failing to immediately notify the the alleged deficient practice: The Administrator of allegations of verbal investigation was initiated on 6/26/11. The Administrator was abuse and failed to ensure an investigation notified of the allegation of abuse was initiated timely and staff suspension on 6/28/11. The employee was at the time of the reported event for 1 of 1 suspended on 6/28/11 pending resident reviewed for allegations of verbal investigation and the initial report was sent to the ISDH via fax on abuse in a sample of 15. (Resident #47) 6/27/11. The investigation was completed and the allegation of Findings include: abuse was unsubstantiated related to the the employee did not have the willful intent to inflict On 6/27/11 at 8:45 a.m., during interview, mental anguish to this resident. Resident # 47's daughter indicated on The employee raised her voice to 6/26/11 sometime after lunch she came the resident.who was across the into the facility after her father had fallen room, in an effort to prevent him and he was sitting in his wheelchair in the from falling due to he was attempting to stand up from his lounge. As she walked up the hallway, wheelchair. The employee she heard LPN # 10 yelling at her father returned to work with counseling from the nurses station to get back into regarding customer service and his wheelchair and to sit down. She 1:1 inservicing on campus guidelines for abuse, stress and indicated she felt the nurse was "mad" at burnout, and appropriate ways to her father because he had fallen and they communicate with residents who were sending him to the hospital. She are hard of hearing. A follow up indicated QMA # 9 had heard LPN # 10 report was sent via fax to the ISDH#2 - Identification of other yelling at her dad. The daughter indicated residents having the potential to she had spoke with Social Worker (SW) # be affected by the same alleged 11 on that day and informed her of the deficient practice and corrective situation and she indicated the SW had actions taken: All residents have the potential to be affected by this

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155698	B. WIN			06/30/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ETHANY RD		
BETHAN	Y POINTE HEALTH	I CAMPUS		1	RSON, IN46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION OF ACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ACH CORRECTIVE ACTION SHOULD BE CON SS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	filled out a form.				alleged deficient practice.#3		
					Measures put into place and		
	Review of a "Res	sident Concern Form"			systemic changes made to ensure the alleged deficient		
	dated 6/26/11 at	1 p.m., completed by SW			practice does not recur: DH	S or	
	# 11 indicated the	e resident's daughter had			designee will review campus		
		e SW after her father had			guidelines with staff for Abus		
		e hospital. She informed			and Neglect Procedures. #4		
		had heard LPN # 10			How the corrective measure be monitored to ensure the	s WIII	
		her. She indicated she			alleged deficient practice do	es	
	* *	irse make derogatory			not recur: DHS or designee		
		past and had heard her			conduct resident interviews		
		-			regarding staff treatment of		
		ear breath when caring			residents. The interviews wi		
		he daughter indicated if			completed on 3 residents, w x 4 weeks then 3	еекіу	
		speak to a resident in that			residents monthly x 5 month	s to	
	_	eople, what might she do			ensure compliance. The au		
	when no one was	s around.			will then be conducted		
					randomly as needed thereaf	ter.	
	A written form d	ated 6/26/11 was			The results of the resident interviews will be reported,		
	provided by the l	Director of Nursing on			reviewed and trended for		
	6/30/11 at 8:40 a	.m. The form was a			compliance thru the campus		
	typed paper signe	ed by the SW. The form			Quality Assurance Committe		
	indicated she had	l spoken to QMA # 9 on			a minimum of 6 months, the	า	
		QMA had informed her			randomly thereafter.		
		10 "yelling" at the					
		and sit down. She further					
	_	t the LPN was "harsh"					
	with the resident. The form indicated she had spoken to the LPN # 10 and the LPN indicated she had only raised her voice						
	because the resident was hard of hearing. The Director of Nursing was informed						
		_					
		I the SW to start a					
	grievance process and she would						
investigate in the morning.							

STREET ADDRESS, CITY, STATE, ZIP CODE TOTAL PETHANY POINTE HEALTH CAMPUS AND SUMMARY STATEMENT OF DEFICIENCIES BETHANY POINTE HEALTH CAMPUS AND SUMMARY STATEMENT OF DEFICIENCIES BRIFTX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) On 6/28/11 at 9 a.m. during interview, OMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended pending investigation. She indicated she had now interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she had now interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she had now interview de eveyone involved	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/30/2	ETED	
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY STATEMENT OF D	NAME OF A	DROLUBER OR GUIRRI IEU		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
CA3 ID SUMMARY STATEMENT OF DEFICIENCIES CEACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CEACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION COMPLE	NAME OF I	PROVIDER OR SUPPLIER	{					
PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) On 6/28/11 at 9 a.m. during interview, QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended pending inversitigation. She indicated she indicated she did not vorked since the event.	BETHAN	IY POINTE HEALTH	1 CAMPUS		ANDER	SON, IN46012		
On 6/28/11 at 9 a.m. during interview, QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she had oft consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had been suspended pending investigation. She indicated she indicated she indicated she of the indicated she indicated she covent.					PROVIDER'S PLAN OF CORE		RECTION	
On 6/28/11 at 9 a.m. during interview, QMA # 9 indicated that on 6/26/11 she had heard LPM # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		`				CROSS-REFERENCED TO THE APPROPRIA	ΤE	
QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she	IAG	REGULATORT OR	LISC IDENTIFTING INFORMATION)		IAG			DATE
QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		On 6/29/11 at 0 a m. during intervious						
had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		,						
was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			•					
her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			-					
the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			1					
been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		On 6/28/11 at 9:	50 a.m., during interview,					
verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		the Administrate	or indicated he had not					
on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		been informed o	f the above allegation of					
interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		verbal abuse.						
interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			_					
above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			_					
Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		indicated she had	d been informed of the					
the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			•					
She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		I	_					
the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		· ·						
had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			*					
not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she								
On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she			•					
interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		not worked since the event.						
interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she		On 6/28/11 at 10):50 a m during					
indicated LPN # 10 had been suspended pending investigation. She indicated she			-					
pending investigation. She indicated she			_					
		1.						
in the above event and the investigation			-					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	
		155698	B. WIN			06/30/2	011
	PROVIDER OR SUPPLIER Y POINTE HEALTH			1707 BI	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Procedural Guide the Administrator	Abuse and Neglect elines" was provided by r on 6/27/11 at 10 a.m., urrent. The policy					
	indicated: "Purp- implemented pro ensure the preven	ose:has developed and cessed, which strive to nation and reporting of ged resident abuse and					
	written or gesture disparaging and o	Abuse-may include oral, ed language that includes derogatory terms to the or within their hearing					
	of their age, abili disabilityThe sl	ribe residents, regardless ty to comprehend or hift supervisor or fied as responsible for					
	initiating and or or process, as follow the Executive Dir	continuing the reporting vs:immediately notify rectorcompleted					
	Executive Direct	ident ReportThe or is responsible for: 1. tate Department of r					
	agenciesProtectemployee(s) pendinvestigationTh	tion:Suspend suspected ding outcome of ne Executive Director is					
	accountable for it reporting"	nvestigating and					
	3.1-28(a)						

INDIPLANOF CORRECTION JOHN THE CATCH COMPLET STREET ADDRESS CITY, STATE, JIP CODE STREET ADDRESS, CITY, STATE, JIP CODE TOY BETHANY POINTE HEALTH CAMPUS STREET ADDRESS, CITY, STATE, JIP CODE TOY BETHANY RD ANDERSON, INAGO12 (X3) ANDERSON, INAGO12 CX3) ANDERSON, INAGO12 CX5) CX60/ILTION SIMMARY STATEMENT OF DEFICIPACIES TO RECOLARCY OR LIST ERECEDED BY FULL FREETY AND EXECUTION OF THE PERCEDED BY FULL ANDERSON, INAGO12 CX5) CAMPLETION DATE TAG RECOLARCY OR LIST EVER DEPROMATION DATE TO RECOLARCY OR COMPLETION (X5) CX60/ILTION DATE TAG RECOLARCY OR LIST EVER DEPROMATION DATE TO RECOLARCY OR COMPLETION CX7) CX60/ILTION DATE TO RECOLARCY OR COMPLETION CX7) CX61/ILTION DATE TO RECOLARCY OR COMPLETION CX7) CX7) CX61/ILTION DATE TO RECOLARCY OR COMPLETION CX7) CX7) CX7) CX7) CX7) CX7) CX61/ILTION DATE TO RECOLARCY OR COMPLETION CX7) CX8) CX8) CX8) CX8) CX8) CX8) CX8) CX9 CX9 CX9 COMPLETION DATE TO RETHANY RD ANDERSON, INAGO12 TO RECOLARCY OR COMPLETION DATE TO RECOLARCY OR COMPLETION TO RETHANY RD ANDERSON, INAGO12 TO RECOLARCY OR COMPLETION TO RETHANY RD ANDERSON, INAGO12 TO RECOLARCY OR COMPLETION CX9 CX9 CX9 CX9 CX9 CX9 CX9 CX	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D.			SURVEY	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SIMMARY STAITMENT OF DEFICIENCIES (EACH DEPICIANY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING REGENATION) SS=D (BACH DEPICIANY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING REGENATION) SS=D (BACH DEPICIANY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING REGENATION) TAG (BACH DEPICIANY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING REGENATION) TAG (BACH DEPICIANY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING REGENATION) TAG (COMPLETION) TAG 1. Corrective actions accomplished for those residents found to have been affected by physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not have a medial condition which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication, residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/for an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for 1 of 4 residents who had physician's order for 1 of 4 residents who had physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, I.PN #12 came into the dining room, spoke to the resident and into the same alleged deficient practice and potential to be affected by the alleged deficient practice and noted no signs/symptoms of hyper/hypoglycemia currenty. Residents with accurbeck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currenty. Residents with soluting scale insuli	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS INCRETINATE (EACH DEPICIENCY MIST EE PERCEDED BY FULL TAG REGULATORY OR LISC IDENTIFYING IMPORMATION) FOREIN AND EACH DEPICIENCY MUST EE PERCEDED BY FULL TAG FOREIGN EACH DEPICIENCY MUST EE PERCEDED BY FULL TAG EACH DEPICIENCY MUST EE PERCEDED BY FULL TAG TAG EACH RESIDENT MUST BE PERCEDED BY FULL TAG TAG EACH RESIDENT MUST BE PERCEDED BY FULL TAG TAG EACH RESIDENT MUST BE PERCEDED BY FULL TAG TAG TAG TAG TAG TAG TAG TAG			155698	1			06/30/2	011
SETHANY POINTE HEALTH CAMPUS 1707 BETHANY RD 200 201				D. WIN		ADDRESS CITY STATE ZIP CODE		
BETHANY POINTE HEALTH CAMPUS IXM ID IXM ID IXM MARY STATEMENT OF DEFICIENCIES TAG REGILATORY OR LISC IDENTIFYING INFORMATION) FOOD SS=D D REGILATORY OR LISC IDENTIFYING INFORMATION) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's order for 1 of 4 residents who had physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, I.PN #12 came into the dining room, spoke to the resident and	NAME OF P	ROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEFICIENCIES THE PRECEDED BY FILL THE PRECED BY FILL THE PRECEDED BY FILL THE PRECED B	BETHAN	Y POINTE HEAI TH	CAMPUS					
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION TAG REGULATORY OR ISC IDENTIFYING INFORMATION OR INFORMATIO					L			
F0309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) puring a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and				PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
Fig. 29 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication, residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's orders for sliding scale insulin received regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #22) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 1 s. Corrective actions accomplished for those residents found to have been affected by the facility failed to ensure a resident shound to have been affected by the alleged deficient peractice. Resident #22 in corrective action was taken at the time of the medication error. Per guideline, Medication Error Circumstance form was complete, MD and family was notified, and nurse was counseled. Resident #22 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin in accordance with the physician's orders for sliding scale insulin accordance with the physician's orders for sliding scale insulin accordance with the physician's orders for sliding scale insulin accordance with the physician's orders for sliding scale insulin accordance with the physician's orders for sliding scale insulin accordance with the physician's orders for sliding scale insulin a		`				E		
must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #22) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #22) and 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and			· · · · · · · · · · · · · · · · · · ·	+	IAG	DEFICIENCE)		DATE
to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accondance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and								
physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed residents with a scorder deficient practice of not receiving medication of other residents having the potential to be affected by the alleged deficient practice of not receiving medication sate of the medication and family was notified and turse was counseled. Resident #21 center #22 and #24 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #25 record review and sliding scale insulin has been administered as ordered per MD	SS=D	•	<u> </u>					
in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the residents who have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed and family succeeding medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents and the physician's order for the reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents and the physician's order for the reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents and the physician's order for the physician's order for 1 of 4 residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accordeck orders records reviewed past 7 days to ensure MD orders were followed.3. Measures								
assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Resident #21) and 2								
facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and								
receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Residents #52 & #44). Findings include: In During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the residents and residents and resident and interviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		Based on intervie	ew and record review, the	F0	309	 Corrective actions 		07/30/2011
receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Residents #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and invested the past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		facility failed to	ensure a resident did not					
by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: by a physician and the residents who was taken at the time of the medication error. Per guideline, Medication Error Circumstance form was complete, MD and family was notified, and nurse was counseled. Resident #52 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Resident with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes							,	
have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and								
treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: Treated by said medication; residents who had symptoms of hypoglycemia received insulin and sassessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes							1011	
were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: Wedication Error Circumstance form was complete, MD and family was notified, and nurse was counseled. Resident #52 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes							ne.	
hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: hypoglycemia received family was notified, and nurse was counseled. Resident #52 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		_	, , , , , , , , , , , , , , , , , , ,			_		
nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the residents and residents was counseled. Resident #52 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no sign/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes						form was complete, MD and		
and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no sign/symptoms of hyper/hypoglycemia. Tecord review and sliding scale insulin has been administered as ordered per MD.2. Identification of ther residents having the potential to be affected by the alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice and corrective actions taken: All residents from the potential to be affected by the alleged deficient practice and service and siding								
condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the residents and disciplination of the resident and sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		nursing services	to address the condition					
results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and insulance insulance insulance insulance and paper into place and systemic changes in hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		and/or an assessn	nent of the residents				ay no	
results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and insulin received and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		condition following	ing abnormal blood sugar				nt	
orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: Findings include: Scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes			_					
insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes			• •			· ·	1	
order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: I.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		_						
regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and residents naving the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the actions taken: All residents have the potential to be affected by the action taken actions and the potential						MD.2. Identification of other		
administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes						• .		
#21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes			-					
the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes			-			•		
alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		,						
receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		reviewed for dial	petic services in a sample			•	'	
(Residents #52 & #44). Findings include: by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		of 15						
Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		(Residents #52 &	z #44).					
Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes								
1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and Signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		Findings include						
1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes							,	
interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		1) During a 6/29	8/11 11·15 a m				<i>y</i> -	
couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes		, ,	· · · · · · · · · · · · · · · · · · ·			_	ed	
the dining room, spoke to the resident and were followed.3. Measures put into place and systemic changes								
the dining room, spoke to the resident and into place and systemic changes		•	-					
as she spoke to the resident she rolled up made to ensure the alleged			•			into place and systemic char		
		as she spoke to the	ne resident she rolled up			made to ensure the alleged		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	LETED
		155698	B. WIN			06/30/2	011
		<u> </u>	D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ETHANY RD		
	IY POINTE HEALTH	1 CAMPUS		1	SON, IN46012		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		rt sleeve. The resident			deficient practice does not re DHS or designee will review		
		I not understand what the			campus guidelines for		
		ated "what?" The			Hyper/Hypoglycemia and		
	Resident #21's ta	ablemate said "She doesn't			Medication administration w	ith	
	get insulin. She'	s not diabetic!" Resident			licensed nurses and QMAs.		
	#21 realized wha	at was happening and			How the corrective action w		
		get insulin." As she was			monitored to ensure the alle		
	_ ·	nat she did not get insulin,			deficient practice does not re DHS or designee will condu		
	_	er an insulin injection.			medication pass observation		
	1	red Resident #21 that yes			nurses or QMAs weekly x 4		
		-			weeks, then 3 nurses or		
		in at supper time and left			QMAs monthly x 5 months t	0	
		13, who the resident knew			ensure compliance. The		
		area. At this time			observations will then be	dad	
	Resident #21 ask	ked if the doctor had put			conducted randomly as nee thereafter. The results of th		
	her on insulin. I	LPN #13 indicated no and			med pass observations will		
	inquired why the	e resident was asking the			reported, reviewed and trend		
	question. When	Resident #21 indicated			for compliance thru the cam		
	she had just beer	n given a shot of insulin,			Quality Assurance Committe		
	1	uickly, investigated what			a minimum of 6 months, the	n	
		d spoke to the doctor.			randomly thereafter. The medication p	200	
		, another employee had			observations will occur on a		
	1	nk an ensure to get			shifts. DHS or designee will		
		_			conduct audit of medication		
		and sugar into her system.			administration records for		
	_	nurses checked her			residents with accuchecks to)	
	_	mber of times. She had			ensure signs/symptoms of		
	_	ecause the nurses acted			hyper/hypoglycemia is asse with intervention and assess		
		nt #21 indicated she later			after intervention documente		
	found out the err	or occurred because LPN			DHS or designee will condu		
	#12 was newer a	nd Resident #21 had a			audit of medication administ	ration	
	similar last name	e to another resident.			records (MAR) for all reside		
	Resident #21 add	ditionally indicated that			with sliding scale insulin ord		
		ollowing the above			to ensure and that sliding so		
	1 -	nurse approached her and			insulin is administered as or per MD. The audits will be	ucieu	
		er a shot for diabetes.			conducted on all residents w	/ith	
	i wanteu to give n	ei a siiot ioi diadetes.					I

NAME OF PROVIDER OR SUPPLIER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD	D11
NAME OF PROVIDER OR SUPPLIER 1707 BETHANY RD	
BETHANY POINTE HEALTH CAMPUS ANDERSON, IN46012	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Comparison of the provider's plan of correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
She indicated she stated a firm no and you have the wrong person. At this time, a CNA stated you have the wrong person, Resident #21 was not diabetic. The nurse stopped what she was doing and went to the station to clarify the situation. 2.) Resident #21's record was reviewed on 6/27/11 at 3:00 p.m. Resident #21's current diagnosis included, but were not limited to, atrial fibrillation and hypertension. The resident did not have a diagnoses of diabetes or receive any form of insulin. Resident #21 had a current, 5/11/11, Minimum Data Sct assessment which indicated the resident was alert, reliable and had intact decision making skills. Review of a 6/20/11, facility "Medication Error Circumstance, Assessment and Interview" form indicated Resident #21 had receive 4 units of Humalog insulin which was ordered for another resident. 3.) During a 6/28/11, 3:05 p.m., interview, LPN #12 indicated she had administered insulin to Resident #21 to 6/15/11 in error because Resident #21's last name was pronounced the same as another resident's last name. She indicated she had misunderstood who the	DATE

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155698	A. BUILDING	00	06/30/2011
		133090	B. WING		00/30/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BETHAN	IY POINTE HEALTH	CAMPUS		ETHANY RD RSON, IN46012	
(X4) ID	_	TATEMENT OF DEFICIENCIES	I ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	resident was and	gave Resident #21			
	another resident's	s medication. She said			
	following the adı	ministration Resident #21			
	indicated she did	not get insulin and LPN			
	#12 went to chec	k the medication			
	administration re	cord and order. She			
	indicated she bel	ieved Resident #21 might			
		r medications correctly.			
		necking the record, LPN			
	1	esident #21's nurse,			
		explained the error of			
		and took over the			
	I -	ng Resident #21's			
		ne indicated she had been			
		wing the error and would			
	I -	the resident's photograph,			
		ed in the medication			
		cord, closely prior to			
	administering an	y medication.			
	During 2 6/28/11	, 2:30 p.m., interview the			
	_	ing indicated, LPN #12			
		eated and received a			
		following the medication			
	ı	ror with Resident #21.			
	She indicated the	e second error which			
	almost occurred	shortly thereafter, was			
		loyee wanting to give the			
		check in error, due once			
	again to misident	tification. She indicated			
	that following that	at event on 6/21/11 all			
	nurses and QMA	s were given a			
	medication admi	nistration inservice to			
	address misident	ification and the			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
ANDILAN	or connection	155698	A. BUIL		00	06/30/20	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ETHANY RD		
BETHAN	Y POINTE HEALTH	CAMPUS			SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		em which was in place.		IAG	DEI TOLERO I I		DAIE
	photograph syste	in which was in place.					
	4.) Resident #52 on 6/27/11 at 10:	's record was reviewed 45 a.m.					
	Dagidant #52's a	arrant diagnagas included					
		urrent diagnoses included, ited to, diabetes mellitus,					
	hypertension.	ned to, diabetes memus,					
	Resident #52 was	s admitted to the facility					
		dent #52 had current,					
	6/15/11, physicia	· · · · · · · · · · · · · · · · · · ·					
	71 3						
	a.) accuchecks ((blood sugar checks)					
	before breakfast,	before lunch, before					
	supper and at bed	ltime.					
		ysician if the resident's lts was less than 60 or					
	c.) administer N	ovolg insulin following					
	· ·	accordance to sliding					
		tion of insulin in various					
	doses in relation	to the obtained blood					
	sugar results).						
	121 to 150 = 4 u						
	151 to 200 = 6 u						
	201 to 250 = 8 u						
	251 to 300 = 12 to						
	301 to 350 = 16 t	• • • •					
	351 to 400 = 20 t						
	401 to 999 = 20 a 	and call physician					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/30/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ETHANY RD		
BETHAN	Y POINTE HEALTH	I CAMPUS		ANDER	SON, IN46012		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG		ng hypokit-inject 1 mg as	+	IAU			DATE
	needed for signs						
	hypoglycemia (low blood sugar) if unable						
	to swallow.	<i>S</i> ,					
	A review of Resi	ident #52's accucheck					
		ng notes indicated the					
	I -	nts of low blood sugar					
		was not notified and the					
		assessed or administered					
		ress low blood sugars					
	such as eating a	-					
	I -	administering glycogen: re breakfast a result of 52.					
	l '	re supper a result of 44.					
	· ·	re supper a result of 49.					
	· ·	re breakfast a result of					
	50.	10 orouniust a rosait or					
		re supper a result of 51.					
		••					
	Resident #52 had	d accuchecks with					
		ılin administration or lack					
		vere not consistent with					
	physician's order						
	l '	re breakfast a result of 131					
		tion of zero insulin given.					
		equired 4 units of insulin					
		liding scale orders. re break a results of 128					
	· ·	tion of zero insulin being					
		result required 4 units of					
	l =	en per sliding scale					
	orders.	L 2					

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155698	A. BUI	LDING	00	COMPL 06/30/2	
		155696	B. WIN			00/30/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RETHAN	Y POINTE HEALTH	CAMPLIS		1	ETHANY RD SON, IN46012		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE	
1710	5.) During a 6/29	· · · · · · · · · · · · · · · · · · ·		mo	<u> </u>		DATE
	'	rector of Nursing					
	· ·	ility did not have any					
		r additional information					
		rding the doctor being					
		ove low blood sugars,					
		ng assessed and offered or treatment when her					
	_	low. She did not believe					
		een notified as she did not					
		ent received any nursing					
		blood sugar was low.					
	l -	above sliding scale					
		ations appeared to be an					
		rder was not followed and					
		not receive insulin per					
	sliding scale.	D :1					
		r Resident # 44 was					
	reviewed on 6/29	9/11 at 10 a.m.					
	G 4 1:						
	_	es included, but were not					
	limited to, Diabe	tes.					
	Dhygiaian and	for June 2011 indicated					
	l	for June 2011 indicated					
		s to be notified of blood					
	_	than 70 and greater than					
	i 400. Origiliai da	te of order was 7/23/10.					
	A plan of care las	st reviewed 5/11					
	_	em of diabetes with					
	_	ncluded, but were not					
	1 ^ ^	-					
	_	significant assessment					
		cian and observe and					
	report sign and s	ymptoms of					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	ì	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1707 E	ADDRESS, CITY, STATE, ZIP BETHANY RD RSON, IN46012	_	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION
TAG	hyperglycemia: polydipsia, abdorvomiting and incommendation of the Medication of April, May, at the following blorecord lacked for signs and symptom sugar. April 1 at supper May 12 at supper May 12 at supper June 11 at supper June 14 at supper June 14 at supper June 14 at supper June 14 at supper June 16 at supper June 24 at supper June 24 at supper June 24 at supper June 3 at supper June 6 (29/11) at 9:3 information was Assistant Director the lack of follow resident with hig	blood sugar was 424. r blood sugar was 425. r blood sugar was 425. r blood sugar was 422. r blood sugar was 422. r blood sugar was 424. r blood sugar was 425. r blood sugar was 427. r blood sugar was 428. r blood sugar was 429. r blood sugar was 449. r blood sugar was 4497. r blood sugar was 4497. r blood sugar was 418.	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
	regarding follow high blood sugar					
		d 11/8/2010 titled Hyper/Hypoglycemia"				

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i			(X3) DATE COMPI	
		155698	B. WIN			06/30/2	011
	PROVIDER OR SUPPLIER			1707 BE	DDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
				<u> </u>	30N, IN40012		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
-		the Director of Nursing		-			
	1 ^ *	5 a.m., and deemed as					
		icy indicated: "Purpose:					
	1	priated medical treatment					
		sidents experiencing					
	1 ^	mic episodes. All					
	residents diagnos	-					
		eive interventions					
	according to thei	r physician order. If the					
	attending physici	ian(s) have not provided					
	specific orders or	n what treatment is to be					
	provided to treat	hypoglycemic episodes,					
	the following gui	idelines will be followed					
	until the attendin	g physician can be					
	contacted. Symp	otoms of					
	hypoglycemia1	. tremors 2. tachycardia					
	3. anxiety 4. diz	zziness 5. headache 6.					
	vision changes 7	. altered mental capacity					
	such as confusion	n or abnormal behaviors					
	Symptoms of hyp						
	increased thirst 2	headache 3. difficulty					
	concentrating 4.	blurred vision 5.					
	_	n 6. fatigue 7. weight					
		ose 50-69give a					
	-	drate oral feeding of one					
	_	*1 tube of glucose gel					
		juice without adding					
	~	of regular soda pop *8					
		t/nonfat milk wait 15					
		eck blood sugar. If					
		es to have a hypoglycemic					
	* *	od sugar <70 (less than),					
		arbohydrate oral feeding					
	Recheck blood s	ugar every 15					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WF4S11 Facility ID:

^{ID:} 011045

If continuation sheet

Page 35 of 63

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMP 06/30/2	LETED
	PROVIDER OR SUPPLIER		1707	ET ADDRESS, CITY, STATE, ZIP COI ' BETHANY RD	DE	
BETHAN	IY POINTE HEALTH	I CAMPUS	AND	ERSON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	minutesuntil sy	mptoms are resolved"				
	3.1-37(a)					
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having necessary treatment healing, prevent ir sores from develod Based on record interview, the factoresident with skirpreventative meanure further sking impairment (Resident # 60) Findings include The record for record fo	review, observation and cility failed to ensure a n impairment had asures implemented to in breakdown would not residents reviewed for in a sample of 15.	F0314	1. Corrective actions accomplished for those found to have been aff the alleged deficient p. Resident #60 was immassessed after being rof the alleged deficient that resident's wounds changed from her most assessment. Bed and were in place and cath was appropriately place cradle was added to the assignment sheet in belettering. 2. Identification residents having the post affected by the same deficient practice and actions taken: All residents having the post affected by the same deficient practice and actions taken: All residents having the post affected by the same deficient practice and actions taken: All residents having the post actions taken: All residents and actions taken: All residents and actions taken: All residents and actions taken and actions tak	fected by ractice: nediately made aware cy. Noted is had not st recent if foot cradle neter tubing ced. Foot he CNA old fon of other potential to ne alleged corrective dent's with observed to e measures, place.3. ce and de to ficient	07/30/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155698	B. WIN			06/30/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DETHAN	V DOINTE LIEALTH	CAMPLIC		1	ETHANY RD		
	Y POINTE HEALTH			ANDER	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU		LSC IDENTIFFING INFORMATION)		IAU			DATE
	catheter. A "Change in Co 6/27/11 at 9:45 a resident had "ma catheter) on (L w leg and the physicream. Skin impairment indicated the resi (cm) by 0.2 cm b cm brown line, a line and a 12 cm the left posterior During a wound 6/28/11 at 1:38 p Resident # 60 wa catheter tubing w left thigh. The L at the time and pocatheter tubing or resident's left thigh thigh remained u the observation. a treatment to an 3rd left toes, she a sheet and a blant top of the resident.	ndition Form" dated .m., indicated the rks from ac (anchored rith a circle around it) left cian had ordered a barrier sheets dated 6/27/11 dent had a 4 centimeter from line, a 7 cm by 0.2 4 cm by 0.2 cm brown by 0.2 cm brown line on thigh. treatment observation on .m., with LPN #18, as in bed, her anchored ras positioned under her PN was informed of this ositioned the anchored			designee will review campus guidelines for Preventative measures for skin with nursir staff. 4. How the corrective action will be monitored to endoes not recur: DHS or designial conduct audit of resident with skin impairment to ensure preventative measures are in place per the resident's plan care. The audits will be completed on all residents with skin impairment 3 times per x 4 weeks, then all resident with skin impairment monthly months to ensure compliance. The audits will then be conducted that the conducted in the skin impairment audits will be reported, reviewed and trend for compliance thru the camp Quality Assurance Committed a minimum of 6 months, there are randomly thereafter.	nsure gnee s re n of ith week s / x 5 ee. ucted eer. led ous e for	
	On 6/28/11 at 2:0	05 p.m., Resident # 60					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY LAN OF CORRECTION IDENTIFICATION NUMBER: 155698 A. BUILDING 00 06/30/2011		ETED				
	PROVIDER OR SUPPLIER Y POINTE HEALTH			1707 BE	DDRESS, CITY, STATE, ZIP CODE THANY RD SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	the bed. The she on the resident's						
	was in bed and the the bed. At that the LPN #3 was information on the bed. S	20 p.m., Resident # 60 ne foot cradle was not on cime, during interview, ormed the foot cradle was the indicated the cradle bed and applied it at that					
	3.1-40(a)(2)						
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infection normal bladder fur Based on observation interview, the fact anchored cathete was positioned in possibility of infereviewed for propanchored cathete	ation, record review, and cility failed to ensure r tubing and drainage bag a manner to prevent the ection for 3 of 3 residents	F031	15	1. Corrective actions accomplished for those resid found to have been affected the alleged deficient practice Resident #60 observed and proper placement of drainage noted during transfer. Resident #59, and #54 cathe tubing observed to not be touching the floor during tran and while seated in w/c. CN. #14 and #15 were immediate	by : e bag tter sfer A	07/30/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WF4S11 Facility ID:

^{ID}: 011045

If continuation sheet

Page 38 of 63

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155698	B. WIN			06/30/2	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF	PROVIDER OR SUPPLIEF	2			ETHANY RD		
BETHAN	IY POINTE HEALTH	I CAMPUS		1	SON, IN46012		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	IAG			DATE
					educated by DHS regarding proper placement of urinary		
	Findings include				drainage bag during transfer	#2 -	
					Identification of other resider		
	1. The record fo	r resident # 60 was			having the potential to be aff		
	reviewed on 6/27	7/11 at 10:45 a.m.			by the same alleged deficien		
					practice and corrective action		
	Current diagnose	ed included, but were not			taken: Residents with cather	ters	
	limited to, neuro				observed to ensure proper placement of drainage bag a	nd	
		geme stader.			tubing during transfer and wh		
	Cumant physicia	m and any fam Luna 2011			seated in w/c. 3. Measures		
	^ *	n orders for June 2011			into place and systemic char	•	
		ident had an anchored			made to ensure the alleged		
	catheter.				deficient practice does not re	cur:	
					DHS or designee will review		
	A plan of care la	st reviewed in 4/11,			campus guideline of Cathete Care with the nursing staff.4.		
	indicated the res	ident had an indwelling			How the corrective action wil		
	catheter and the	drainage bag was to be			monitored to ensure the alleg		
	maintained below	w the level of the bladder.			deficient practice does not	^	
					recur: DHS or designee will		
	During a care an	d transfer observation on			conduct observation on all		
	_	a.m., CNA # 14 and # 15			residents with catheters to en		
					proper placement of drainage		
	1	ent's room. They placed			and tubing during transfers a while seated in w/c. The	iiiu	
		er the resident. CNA # 14			observations will be complete	ed 3	
	1 ^	inchored catheter			times per week x 4 weeks, t		
	1 -	I tubing on the resident's			all residents with catheters		
	stomach in the b	ed. There was urine in			monthly x 5 months to ensur		
	the bag and tubin	ng. The CNA asks the			compliance. The observation	ns	
	resident to hold	onto the hook of the			will then be conducted randomly as needed thereaft	er	
	anchored cathete	er which she does. During			The results of the observatio		
		nchored catheter drainage			will be reported, reviewed an		
		emained on the resident's			trended for compliance thru t		
	"	he level of the bladder.			campus Quality Assurance	_	
		in it is a me aluduoi.			Committee for a minimum of	6	
	2 The record for	r resident # 59 was			months, then randomly thereafter. The observations	. will	
					occur on all 3 shifts.	o vviii	
	reviewed on 6/28	s/11 at 2:30 p.m.			Jocui on an J Sillis.		

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155698	B. WIN			06/30/2011
		<u> </u>	P. (12)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>		1707 BI	ETHANY RD	
	Y POINTE HEALTH	I CAMPUS			RSON, IN46012	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BETTELENCT)	DATE
	G 1:					
		es included, but were not				
	limited to urinary	y retention.				
		s for June 2011 indicated				
	the resident had	an anchored catheter.				
		10 a.m., the resident was				
	_	n dining room in her				
	wheelchair. Her	anchored catheter tubing				
	was on the floor	under her wheelchair. At				
	that time, RN # 1	7 was informed the				
	tubing was on the	e floor. She then				
	adjusted the tubi	ng so it would not be on				
	the floor.					
	3. On 6/27/11 fr	om 11:40 a.m. to 11:55				
	a.m., Resident #5					
	· ·	CNA #1 and LPN #3				
		dent for her transfer, the				
		sferred from her bed to				
		During this transfer the				
		atheter tubing was				
	I	-				
		floor. Yellow, cloudy				
		sediment was observed				
	in the foley cathe	eter tubing.				
	On 6/28/11 from	1:10 p.m. to 1:25 p.m.,				
		ansfer was observed.				
		nd QMA #9 prepared the				
		ransfer, the resident was				
		her wheelchair to the				
		transfer, the resident's				
	1	oing was observed to be				
	dragging on the f	floor. Yellow, cloudy				

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID IT SUMMARY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IT IN White sediment was observed in the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3.35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantion-mone (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was due to urinary retention.	STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PERCEDED BY PULL. TAG REGULATORY OR LSE DEBINITYMING INFORMATION) urine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Wirine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was			155698	- 1			06/30/2	011
BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Urine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was				B. WII.		ADDRESS, CITY, STATE, ZIP CODE	l	
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	NAME OF I	PROVIDER OR SUPPLIEF	8					
RECHAMBLE TAGE COMPLETION TAG REQULATORY OR LSC IDENTIFYING INFORMATION) Urine with white sediment was observed in the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was	BETHAN	IY POINTE HEALTH	1 CAMPUS		1			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) urine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was								
urine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		`				CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	
in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was	TAG	+	· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCY)		DATE
time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was								
tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		1						
should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		· ·	-					
in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		_						
Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		should had been	sure all of the tubing was					
6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		in the dignity bag	g prior to the transfer.					
6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		Resident #54's re	ecord was reviewed on					
diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was								
to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		_						
and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		1 ~						
data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was			_					
indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		1						
requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was								
an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was			_					
The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was								
Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		an indwelling ca	theter.					
milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		The physician or	der, dated 3/07/11, was					
bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		Nitrofurantoin-m	nono (Macrobid) 100					
The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was		milligram give 1	capsule by mouth every					
6/03/11, indicated the foley catheter was		bedtime for chro	nic sepsis.					
6/03/11, indicated the foley catheter was		The mentleter is	raina aggaggerant datad					
		1	_					
due to urinary retention.								
		due to urinary retention.						
4. The "CATHETER CARE		4. The "CATHETER CARE						
(INDWELLING CATHETER)" policy		(INDWELLING	CATHETER)" policy					
was provided by the Director of Nursing								
on 6/29/11 at 8:45 a.m. This current			_					
policy indicated the following:								
		1 1 1 1 1 1 1 1 1 1	<u>.</u> .					
"Purpose		"Purpose						
		1. To prevent in	fection					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	BER: COMPLETED COMPLETED				ETED
		155698	A. BUILDING B. WING 06/30/2011				011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1707 BE	ETHANY RD		
	Y POINTE HEALTH	CAMPUS		ANDER	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	2. To reduce irri	tation					
	* A 1.11/1 1 1.	. C					
	* Additional in	nfection control					
	measures:						
		catheter is below the					
	level of the blade						
		theter tubing away from					
	the floor"						
	3.1-41(a)(2)						
F0328		nsure that residents receive					
SS=D	proper treatment a special services:	and care for the following					
	Injections;						
	Parenteral and en	teral fluids;					
		ostomy, or ileostomy care;					
	Tracheostomy car						
	Tracheal suctionin	g;					
	Respiratory care;						
	Foot care; and Prostheses.						
		ation, record review, and	F03	128	Corrective actions		07/30/2011
			1.03	,20	accomplished for those resid	ents	07/30/2011
		acility failed to ensure a			found to have been affected		
		was regulated by			the alleged deficient practice		
	•	el for 1 of 1 resident			DHS immediately educated (CNA	
	observed in a san	nple of 15.			#2 regarding the need for a	yaan	
	(Resident #16)				licensed nurse to turn on oxy for any resident. Resident #		
					oxygen was set at the flow ra		
	Findings include	:			per MD order.#2 - Identificat		
					of other residents having the		
	1. On 6/27/11 fro	om 11:25 a.m. to 11:40			potential to be affected by the		
	a.m., Resident #1	6's transfer was observed			same alleged deficient practi- and corrective actions taken:		

STATEMEN	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155698	B. WIN			06/30/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		1	ETHANY RD		
RETHAN	Y POINTE HEALTH	I CAMPUS		1	SON, IN46012		
				L			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		<u> </u>	DATE
	-	CNA #2. After the			residents who receive oxyge have the potential to be affect		
		r from her bed to her			by the same alleged deficien		
	chair using the H	Ioyer lift was completed,			practice.3. Measures put into		
	CNA #2 was obs	served to put the resident's			place and systemic changes		
	nasal canula in p	lace and turn the portable			made to ensure the alleged		
	oxygen on. At tl	his same time during an			deficient practice does not		
		#1 And CNA # 2 both			recur: DHS or designee will	<u>,</u>	
	ŕ	ident's oxygen was			review campus guidelines for Administration of Oxygen wit		
		ers per minute. The			nursing staff.4. How the		
		n transferred to the dining			corrective action will be mon	itored	
	room for lunch.	i transferred to the diffing			to ensure the alleged deficie		
	100iii ioi iuiicii.				practice does not recur: DHS		
	0 (100/11)	40 1 :			designee will conduct observ		
		40 a.m. during an			audit on CNA caring for resid with oxygen to ensure the	ents	
		#1 indicated after			campus guidelines for oxyge	n	
	positioning an ox	xygen canula on a			administration are followed.		
	resident, she wor	ald set the oxygen flow to			audits will be completed on 5		
	the proper liters.				residents receiving oxygen		
					weekly x 4 weeks, , then 5		
	On 6/30/11 at 8:4	45 a.m. during an			residents monthly x 5 months		
		rector of Nursing (DON)			ensure compliance. The au will then be conducted	uits	
		censed personnel, not			randomly as needed thereaft	er.	
	-	regulate a resident's			The results of the audits will		
	•	•			reported, reviewed and trend	led	
	oxygen flow rate	<i>.</i>			for compliance thru the camp		
	0 D :1				Quality Assurance Committe		
		s record was reviewed on			a minimum of 6 months, ther randomly thereafter. The	1	
		.m. The resident's			observations will occur on all	3	
	_	ed, but were not limited			shifts.		
		mentia, pneumonia, and					
	left sided hemipa	aresis.					
	The physician or	der, dated 1/28/11, was					
		s per minute continuously					
	per nasal canula.						

011045

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED				ETED			
155698 A. BUILDING B. WING					06/30/2	011	
			P:		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ETHANY RD		
BETHAN'	Y POINTE HEALTH	I CAMPUS			SON, IN46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	3. The "GUIDE!	LINES FOR					
	ADMINISTRAT	TON OF OXYGEN"					
	policy was provi	ded by the DON on					
		p.m. At this same time					
		ew, the DON indicated					
	_	t specify the licensed					
		ulate the oxygen flow but					
	_						
	the policy should	1.					
	3.1-47(a)(6)						
	3.1-7/(a)(0)						
F0329	Each resident's dr	ug regimen must be free	İ				
SS=E	from unnecessary	drugs. An unnecessary					
		hen used in excessive dose					
		e therapy); or for excessive					
		ut adequate monitoring; or					
	-	indications for its use; or in diverse consequences which					
	•	should be reduced or					
		ny combinations of the					
	reasons above.	,					
	•	rehensive assessment of a					
		ry must ensure that					
		e not used antipsychotic n these drugs unless					
		therapy is necessary to					
		ndition as diagnosed and					
	-	e clinical record; and					
		antipsychotic drugs receive	1				
		ctions, and behavioral					
		ess clinically contraindicated,	1				
		ontinue these drugs.	F0.2	20	1 Corrective actions		07/20/2011
		reviews and interviews,	F03	29	 Corrective actions accomplished for those resid 	ente	07/30/2011
	_	to ensure residents			found to have been affected		
	receiving psycho	active medications had			the alleged deficient practice		
	gradual dosage re	eductions and/or			MD will be contacted for Res		
	statements of cor	ntraindication related to			#51, #6, #54 and #44 and red	quest	

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155698	B. WIN			06/30/20	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	ETHANY RD		
DETUAL	IY POINTE HEALTH	L CAMPILIS		1	SON, IN46012		
DETHAN	T FOINTE HEALT	1 CAMP 03		ANDER		_	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the denial of a gr	radual dosage reduction			a statement of contraindication		
	for 4 of 4 resider	nts reviewed for gradual			related to their last denial of	a	
	dosage reduction	ns in a sample of 15.			gradual dose reduction. #2 - Identification of other resider	, _{to}	
	(Resident #'s 51,	•			having the potential to be aff		
	(resident # 5 5 1,	, 0, 2 1, and 1 1)			by the same alleged deficien		
	Fig. 41				practice and corrective action		
	Findings include) :			taken: All residents on		
					psychoactive medications ha	ive	
	1. Resident #51	's record was reviewed on			the potential to be affected b		
	6/27/11 at 2:15 p	o.m. The resident's			same alleged deficient practi		
	diagnoses includ	led, but were not limited			During their next gradual dos		
	to, Alzheimer's o				reduction review, will reques		
	hallucinations/de				statement of contraindication	I IT	
		ciusions.			the MD disagrees with the recommendations.3. Measu	rec	
		1.6 1.61			put into place and systemic	163	
	1 -	ecommendation, dated			changes made to ensure the		
	9/20/10, was to 6	decrease Klonopin 0.5 mg			alleged deficient practice do		
	twice daily to K	lonopin 0.25 mg by mouth			not recur: DHS met with Med		
	2 times a day.				Director. He assisted with		
					developing a new procedure	for	
	The physician's	orders, dated 9/29/10,			obtaining statements of		
	were to discontin				contraindication related to the	e	
					denial of a gradual dose reduction. Statements of		
		g and to start Klonopin			contraindications related to the	he	
	0.25 mg 1 by mo	outh 2 times a day.			denial of a gradual dose		
					reductions will be added to e	ach	
	The physician's	order, dated 10/25/10,			pharmacist recommendation		
	was Clonazepan	n (Klonopin) 0.5 mg			to submitting to the MD for		
	_	e 1 tablet by mouth 2			review.4. How the corrective		
	`	inxiety, which was an			action will be monitored to er		
	_	e prior dose. The record			the alleged deficient practice		
		_			does not recur: DHS or desi	gnee	
	1	mation of increase			will audit all pharmacy recommendations every		
		"PRN (AS NEEDED)			month related to gradual dos	.e	
		TRACKING" records for			reductions to ensure the MD		
	9/10 and for 10/	10 indicated no additional			included a statement of		
	Klonopin was ac	lministered.			contraindication related to the	e	
	<u> </u>				denial of a gradual dose		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ì	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED (2011
		155698	B. WING		06/30	12011
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	CODE	
BETHAN	NY POINTE HEALTH	H CAMPUS		RSON, IN46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	1	RLY ANTIPSYCHOTIC		reduction. Any reco		
	1	AND GDR (GRADUAL		re-submitted to the		
	1	ΓΙΟΝ)" record, dated		corrections. These		
		ed the diagnosis was	completed each month to			
		allucinations. The		compliance and reported thrucampus Quality Assurance		
	1 ^	reduction date was		campus Quality Assurance Committee.		
		chaviors were indicated as				
	1 "	dered, and would get into				
	other resident's l	belongings.				
		mation was indicated				
	1	wiors or a possible GDR				
	related to the me	edication, Klonopin.				
	On 6/29/11 at 2:	30 p.m. during the daily				
	1	meeting, information was				
	1	rning Resident #51's				
	Klonopin use/ra	_				
	Trionopin ase, ra	nonare.				
	On 6/30/11 at 8:	45 a.m. during an				
	interview, the D	irector of Nursing				
	indicated she ha	d no further information				
	concerning Resi	dent #51's behaviors				
	and/or physician	s rationale for denial of				
	drug reduction.					
	2 Resident #6's	s record was reviewed on				
		a.m. The resident's				
		ded, but were not limited				
	1	syndrome, sleep apnea,				
	insomnia, and h					
	msomma, and ii	yurocepharus.				
	The physician of	rder, dated 10/29/09, was				
	1	yrel) 50 milligrams (mg)				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE :	ETED
		155698	B. WIN			06/30/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	NY POINTE HEALTH	H CAMPUS		1	ETHANY RD SON, IN46012		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
	bedtime for inso	mg) by mouth every					
	beduine for miso	iiiiia.					
	The "OUARTER	RLY ANTIPSYCHOTIC					
	· -	AND GDR (GRADUAL					
	1	ΓΙΟΝ)" record, dated					
		ted the diagnosis was					
	1	nterdisciplinary Risk					
	1	am recommended "drug					
	holiday" with 9	days on and 1 day off.					
	The pharmacy re	ecommendations, dated					
	10/21/10 and 4/1	14/11, indicated it was					
	time to consider	a dosage reduction for					
	Desyrel 25 mg a	t bedtime. The physician					
	had disagreed or	n each recommendation					
	with no rational	e given for the denial.					
	On 6/29/11 at 2:	30 p.m. during the daily					
		meeting, information was					
	requested concer	rning Resident #6's					
	Desyrel use/ration	onale.					
		's record was reviewed on					
	1 -	o.m. The resident's					
	1	led, but were not limited					
	to, insomnia.						
	The physician's	order, dated 10/21/09,					
	1	nilligrams (mg) by mouth					
	every bedtime for						
	every bedime it	n mooning.					
	The "OUARTER	RLY ANTIPSYCHOTIC					
	1	AND GDR (GRADUAL					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/30/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	" }	_		ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	IY POINTE HEALTH	I CAMPUS		1	ETHANY RD ISON, IN46012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		FION)" record, dated ed the diagnosis was					
	1 '	ast attempted drug					
	reduction was 4/						
		he Interdisciplinary Risk					
		am recommended to					
	request a GDR p						
	recommendation	S.					
		ecommendations, dated					
		4/11, indicated it was					
		a dosage reduction for bedtime. The physician					
	1	each recommendation					
	I -	e given for the denial.					
	, , , , , , , , , , , , , , , , , , ,	Siven for the denimin					
	On 6/29/11 at 2:	30 p.m. during the daily					
	exit conference i	neeting, information was					
	1 -	rning Resident #54's					
	Lunesta's use/rat	ionale.					
	On 6/29/11 at 10	2:25 a.m. during an					
		irector of Nursing					
	1	ning Resident #'s 6, 54,					
		ot have any statements					
	from the physici	-					
	contraindication	s related to the decline to					
	accept a gradual	_					
	' ' ' ' ' ' ' '	or Resident # 44 was					
	reviewed on 6/29	9/11 at 10 a.m.					
	The June 2011 n	hysician orders indicated					
		neron 15 milligrams daily					
		epression. The original					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WF4S11 Facility ID: 011045

If continuation sheet

Page 48 of 63

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET					
ANDILAN	or connection	155698	A. BUI			06/30/2011	
		10000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF F	PROVIDER OR SUPPLIER				ETHANY RD		
BETHAN	Y POINTE HEALTH	CAMPUS			SON, IN46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	date of the order	was 7/8/10.					
	A plan of care las						
	indicated the resident utilized an						
	antidepressant ar	nd interventions included,					
	but were not limi	ited to, work with					
	physician/pharm	acy to provide lowest					
	therapeutic dosag	ge.					
	A "Note to Attending						
	Physician/Prescriber" form from the						
	pharmacist dated 9/7/10 indicated a						
	-	to reduce the resident's					
	Remeron and the	resident's Lexapro.					
		s are used to treat					
		form indicated the					
	_	to reduce the Lexapro					
		was to stay at the same					
		le was indicated why the					
		t reduced at this time.					
	remeron was no	t reduced at time time.					
	A "Note to Atten	ding					
		iber" form from the					
		3/9/11 indicated a					
	•	to reduce the resident's					
		hysician had checked the					
	_	failed to indicate a					
	_	e Remeron should not be					
	<u>-</u>	me. The Director of					
		signed and dated the					
	recommendation	_					
	Tecommendation	OH J/ 1/ 11.					
	5. A Policy titled	1 "I Innecessary					
	<u>-</u>						
	wiedications wa	s provided by the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		(X2) MULTIPLE CO A. BUILDING D. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/30/2011	
	PROVIDER OR SUPPLIER		1707 BI	ADDRESS, CITY, STATE, ZIP CODE ETHANY RD RSON, IN46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Director of Nurs	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ing on 6/30/11 at 12:20	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	p.m., and deemed indicated: "III. gradual Dose Rebased on the phy that: a. A GDR the resident's fundistressed behaviorstability by examedical or psych Continued use of accordance with documentation pelinical rational alikely to impair for stability. c. The or worsened after attempt and documents is (SIC)	d as current. The policy Contraindications to ductions (GDR) will be sician's determination would be likely to impair			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698			(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 06/30/2011
NAME OF I	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
BETHAN	Y POINTE HEALTH	CAMPUS		BETHANY RD ERSON, IN46012	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	`			CROSS-REFERENCED TO THE APPROPRIA	re
PREFIX TAG F0356 SS=C	REGULATORY OR The facility must p on a daily basis: o Facility name. o The current date o The total numbe worked by the follo and unlicensed nu responsible for res - Registered n - Licensed pra vocational nurses law) Certified nurs o Resident census The facility must p specified above or beginning of each as follows: o Clear and reada o In a prominent p residents and visit The facility must, u make nurse staffin public for review a community standa The facility must in nurse staffing data months, or as requ whichever is great Based on observa	r and the actual hours bwing categories of licensed rsing staff directly sident care per shift: urses. ctical nurses or licensed (as defined under State se aides. s. ost the nurse staffing data n a daily basis at the shift. Data must be posted ble format. lace readily accessible to ors. upon oral or written request, g data available to the t a cost not to exceed the rd. naintain the posted daily for a minimum of 18 uired by State law, er. ation and interview, the	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) 1. Corrective actions	07/30/2011
	posted daily and of 4 days of the s			accomplished for those resident to have been affected the alleged deficient practice residents were affected by the deficient practice.#2 - Identification of other resider having the potential to be affected by the same alleged deficient practice and corrective actions.	by : No iis its ected t

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	ISTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155698	B. WING	i		06/30/2	011
NAME OF P	ROVIDER OR SUPPLIER			STREET AI	ODRESS, CITY, STATE, ZIP CODE		
					THANY RD		
BETHAN	Y POINTE HEALTH	CAMPUS		ANDERS	SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE	
	Findings include	:			taken: No residents were affected by this alleged deficient		
	On 6/28/11 at 10	:50 a.m., the staffing		practice.3. Measures put into			
	posted was for 6/	_			place and systemic changes made to ensure the alleged		
	posted was for 6/27/11 (worlday).				deficient practice does not re	cur.	
On 6/29/11 at 12:15 p.m., the staffing				DHS will review the guideline			
					for required daily staff posting	g	
	posted was for 6/	28/11 (Tuesday).			with the ADHS and weekend		
	0 (100111) 0 1	10 11 10			nursing managers.4. How th		
	On 6/30/11 at 8:10 a.m., the staffing posted was for 6/28/11 (Tuesday). At this same time during an interview, the Assistant Director of Nursing indicated				corrective action will be moni to ensure the alleged deficier		
					practice does not recur: DHS		
					designee will audit/observe s		
					posting to ensure it is posted		
	she would post th	ne staffing. She also			daily. The audit will be comp	leted	
	indicated she wo	uld usually have the			5 times per week x 4 weeks,		
	information prep	ared the day before and			then monthly x 5 months to ensure compliance. The aud	dite	
		me kept at the nurse's			will then be conducted	مال	
	station.	•			randomly as needed thereaft	er.	
					The results of the audit will be		
	3.1-13(a)				reported, reviewed and trend		
	3.1 13(u)				for compliance thru the camp		
					Quality Assurance Committee a minimum of 6 months, then		
					randomly thereafter.	'	
F0365 SS=D		eives and the facility pared in a form designed to eds.					
		review, observation, and	F03	365	1. Corrective actions	l	07/30/2011
		cility failed to ensure			accomplished for those resid		
		were served in the form			found to have been affected	, ,	
	•	nysician for 2 of 3			the alleged deficient practice Resident #60 whole hot dog		
	• •	ed for proper food and			removed and ground meat		
	liquid texture in a	* *			hotdog served when alleged		
	(Resident # 60 ar	-			deficiency noted. Resident #	44	
	(Resident # 60 at	iu # 44)			now receiving pre-thickened		
					liquids.2. Identification of oth		
	Findings include	:			residents having the potentia be affected by the same alleg		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	TED
		155698	B. WIN			06/30/20	11
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEF	8		1	ETHANY RD		
RETHAN	IY POINTE HEALTH	I CAMPLIS		1	SON, IN46012		
	-		_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					deficient practice and correc		
	1. The record for	or Resident # 60 was			actions taken: All residents v mechanically altered diets ar		
	reviewed on 6/2	7/11 at 10:45 a.m.			thickened liquid orders have		
					potential to be affected by th		
	Physician orders	for June 2011 indicated			same alleged deficient practi		
	the resident was on a regular diet with				Residents observed during r	neal	
	ground meat. Original date of the order				time to ensure correct diet		
	1 -				received. New powdered		
	was 2/15/11.				thickener was ordered with	do	
	A plan of care dated 2/15/11 indicated a				instructions for thickening liq located directly on the can.		
					pre-thickened liquid has bee		
	problem of resident not chewing meats				ordered for staff use on	"	
	and is at risk for	choking.			medication carts.3. Measure	es put	
					into place and systemic char		
	On 6/27/11 at 5:	02 p.m., Resident # 60			made to ensure the alleged		
		upper tray consisting of a			deficient practice does not re	ecur:	
	1	n a bun. She was served			Dietary Manager will review		
	1				guidelines for reading tray ca		
	1 -	of Nursing. At 5:12 p.m.,			and serving food in correct fo with dietary staff. DHS or	ן ווווכ	
	1	empted to cut up the hot			designee will review guidelin	es for	
	dog but could no	ot hold the knife tight			reading tray cards, use of		
	enough. At 5:15	p.m., an unidentified			pre-thickened liquids, use of		
	dietary worker h	elped the resident with a			powdered thickener with		
	clothing protecto	or and cut up the hot dog.			instructions for thickening on	the	
		etary Aide # 19 was			side of the can. 4. How the		
	1	esident # 60 was to have			corrective action will be mon to ensure the alleged deficie		
		ne indicated during			practice does not recur: DH		
	~	•			designee will audit thickened		
		time, the tray card did			liquid orders to ensure corre		
		dent identified as needing			consistency is served. Audit		
	-	t 5:21 p.m., the resident			be completed on 4 residents		
	1	of the hot dog and began			weekly x 4 weeks, , then 4	_	
	eating it. At 5:2	7 p.m., the Director of			residents monthly x 5 month		
	Nursing was info	ormed the resident was to			ensure compliance. The au will then be conducted	aits	
	1 -	eat diet. She removed			randomly as needed thereaf	ter	
	1	y. At 5:30 p.m., the			The results of the audits will		
	1	ved a ground meat hot			reported, reviewed and trend		

011045

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155698	B. WIN			06/30/2	011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2			ETHANY RD			
BETHAN	IY POINTE HEALTH	I CAMPUS		1	SON, IN46012			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE	
	dog.				for compliance thru the cam			
					Quality Assurance Committe a minimum of 6 months, the			
	2. The record fo	r resident # 44 was			randomly thereafter. Dietary			
	reviewed on 6/29/11 at 10 a.m.				Manager or designee will au			
	30,300,700,000,000,000,000,000,000,000,0				compliance in serving correct			
	Current physicia	n orders for June 2011			mechanically altered diets a			
	Current physician orders for June 2011 indicated the resident was to have nectar				correct reading of tray cards			
		ident was to have nectal			Audit will be completed on a	II		
	thick liquids.				residents with order for	ook v		
					mechically altered diet 3 x w 4 weeks, , then all residents			
	_	tion pass observation on			order for mechanially altered			
	6/28/11 at 11:25 a.m., LPN # 3 prepared				monthly x 5 months to ensu			
	the resident water	er to drink by pouring			compliance. The audits will	then		
	thickener into th	e water from a plastic			be conducted randomly as			
	container. She d	id not measure the			needed thereafter. The resu	ılts of		
	thickener. The v	vater was pudding thick		the audits will be reported, reviewed and trended for				
	and would not po	our from the cup as the			compliance thru the campus			
	1	drink the water with her			Quality Assurance Committee			
	medication. At t	hat time during			a minimum of 6 months, the			
		# 3 indicated she gauged			randomly thereafter. The au	dits		
		testing with a spoon. She			will include all 3 meals.			
	1	poon stood up in the						
	water it was hon	-						
	water it was non	cy unex.						
	3. A 2009 policy	y titled "Thickened						
		ovided by the Director of						
	1 ^ ^	/11 at 8:45 a.m., and						
	_	nt. The policy indicated:						
		ck liquids are easily						
		comparable to apricot						
	1 -	cream soups5. If						
		keners are use, the						
		·						
		nstructions will be						
		re that the appropriate						
	consistency is pr	ovided"						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		A. BUII	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/30/2	ETED	
	PROVIDER OR SUPPLIER Y POINTE HEALTH		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0371 SS=E	Meal/Tray and Tray the Director of 8:45 a.m., and depolicy indicated: followed to ensure served" 3.1-21(a)(3) The facility must-(1) Procure food from considered satisfal local authorities; a (2) Store, prepare, under sanitary corniterview, the fact handwashing was to prevent the poinfections and disserving meals and in the 600 dining dining rooms obshad the potential residents eating or room. (CNA #2, Dietary (600 Dining room) Findings include 1. On 6/27/11 from	distribute and serve food distribute and serve food ditions ations, record review, and cility failed to ensure a completed in a manner stential spread of sease for 3 of 6 staff d for 2 of 2 observations a groom and for 1 of 3 served. This deficiency to impact 19 of 70 daily in the 600 dining by server #6; CNA #7)	F0	371	1. Corrective actions accomplished for those resid found to have been affected the alleged deficient practice. Upon notification of this alleg deficient practice, all 600 hal dietary and CNA staff were inserviced regarding guidelin for hand washing, disposal o soiled paper towels and serv and clearing tables. 2. Identification of other resider having the potential to be affeby the same alleged deficien practice and corrective action taken: All residents who eat the 600 hall dining area have potential to be affected by this same alleged deficient practice. 3. Measures put into place and systemic changes made to ensure the alleged	by : :ed I :es f ing its ected t ins in e the is	07/30/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED	
		155698	B. WIN			06/30/2	011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	!		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ETHANY RD			
	IY POINTE HEALTH	1 CAMPUS		ANDER	SON, IN46012			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	deficient practice does not re	001151	DATE	
	1	NA #2 was observed to			Dietary Manager, DHS and	ecui.		
	put a hair net on from her pocket, enter the kitchen, and return with coffee 2				designees will review campu	ıs		
					guidelines for hand washing	,		
		nd ice water in a pitcher			disposal of soiled paper tow			
		o handwashing was			and protocol for serving and			
	1	these trips in and out of			clearing tables with nursing dietary employees.4. How t			
	the kitchen.				corrective action will be mor to ensure the alleged deficie	itored		
	2. On 6/27/11 fr	rom 4:35 p.m. to 5:15			practice does not recur: Dietary			
	1	observed. While waiting	Manager or designee will observe					
	on the remaining residents to come into				hand washing procedures in	the		
	the dining room for their meal, Dietary				600 hall dining area for 3 employees 3 times per weel	. v 1		
	1	oserved to rinse the soiled			weeks, , then 3 employees	\ \ \ \		
		load them into the			monthly x 5 months to ensu	ire		
	1	xt, Dietary server #6 was		compliance. The audits will then				
		dwash for 12 seconds		be conducted randomly as				
		towels onto the top of a		needed thereafter. The results of the audits will be reported, reviewed and trended for				
	1 -	andwashing sink. Then,						
	1	essert tray of pudding			compliance thru the campus	;		
	1				Quality Assurance Committee			
	_	rator and the package of			a minimum of 6 months, the			
		After the whipped cream			randomly thereafter. The au will be conducted during all			
	1 ^ ^	f the pudding servings,			meals served.			
		serve the individual						
	pudding serving							
		served to handwash in the						
	1	e her used paper towels						
	1 -	ne cart next to the						
	1	ık. Dietary server #6 was						
	1	handgel, entered the						
	kitchen, and obta	ained a chocolate						
	individual puddi	ual pudding and a vanilla						
	individual puddi	ng from the refrigerator.						
	After serving the	ese puddings to 2 different						
	residents in the	lining room, Dietary						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155698		A. BUILDING		NSTRUCTION 00	(X3) DATE: COMPL 06/30/2	ETED	
	PROVIDER OR SUPPLIER		170)7 BE	DDRESS, CITY, STATE, ZIP CODE THANY RD SON, IN46012	00/00/2	· · ·
				DEN	3011, 11140012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	server #6 was ob away, scraped a kitchen, and hand seconds placing same top shelf of handwashing sinknife for a visitor individual glasse out into the dining CNA #7 was agakitchen, handwas placed the used present to the handwas same time during server #6 indicate for 20 seconds an activities, for exadishes and servir indicated there was available in the khandwashing since 3. The "Hand W provided by the 6/29/11 at 8:45 a indicated the follow "POLICY: Emp	served to throw trash plate off, entered the dwashed for less than 10 the used towels on the fa cart next to the k. She, then, obtained a r to cut a sandwich, 2 s of ice water, and back ag room passing desserts. in observed in the shed for 15 seconds, and paper towels on the cart washing sink. At this g an interview, Dietary ed one should handwash and between the different ample, picking up soiled ag food. She also was no wastebasket eitchen next to the k. Sashing" policy was Director of Nursing on .m. This current policy owing: loyees will use proper chniques to prevent the on.					

011045

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<u> </u>	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
		155698	B. WIN			06/30/2	011
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
BETHAN	Y POINTE HEALTH	I CAMPUS		1	ETHANY RD SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A. When entering Department.	ng the Nutrition Services					
	C. After handlutensils.	ing soiled dishes and					
	E. Before and	after handling foods.					
	2. Hand washing procedure:						
	B. Add soap and rub well, especially between fingers and around and underneath fingernails for a minimum of						
	20 seconds.						
		towel to lift garbage can dispose of paper					
	was provided by on 6/30/11 at 8:3	dicated as eating in this					
	C	y.					
	3.1-21(i)(2)						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/30/2011
	PROVIDER OR SUPPLIER Y POINTE HEALTH		STREET 1707 I	ADDRESS, CITY, STATE, ZIP CODE BETHANY RD RSON, IN46012	
				1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0441 SS=D	The facility must e Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection.			
	Program under wh (1) Investigates, confections in the fa (2) Decides what pisolation, should be resident; and (3) Maintains a reconstruction	stablish an Infection Control nich it - ontrols, and prevents			
	determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease. (3) The facility must hands after each communication is specified in the communication in the communication in the communication is specified in the communication in the communication in the communication is specified in the communication in the co	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted			
	transport linens so infection. Based on observa- record review, th infections contro- following in a ma	andle, store, process and a sto prevent the spread of ations, interview, and e facility failed to ensure I practices were anner to prevent the spread of infections and	F0441	Corrective actions accomplished for those resided found to have been affected the alleged deficient practice. Upon notification of the alleged deficient practice all nursing.	by :: ed

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		(X2) MULTIF A. BUILDING B. WING	G 00	(X3) DATE COMP 06/30/2	LETED
NAME OF PROVIDER OR SUPPLIE		ST1	REET ADDRESS, CITY, STATE, ZIP COI '07 BETHANY RD NDERSON, IN46012	DE	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TA	PROVIDER'S PLAN OF CORRE FIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE
use during pers 5 nursing staff 6 #3) and for 2 of (Resident #16 at foley catheter here) for 1 of 1 resided #60) and for 1 of transfer (CNA #dressing change observed (LPN observed (Resident #16's observed. As the removed, CNA had been incomplosely formed #1 with gloved complete the resident #1 to side assist with positional under the resided gloves. Next, so obtained the Household was a side of the Household was a side	,		were inservice regarding guidelines on hand wa glove use during care, drainage bag and tubir placement, carrying treand out of resident rook cleaning equipment priafter use for treatments Identification of other inhaving the potential to by the same alleged depractice and corrective taken: All residents has potential to be affected same alleged deficient practice. 3. Measures place and systemic chamade to ensure the alledeficient practice does recur: DHS will review following guidelines wistaff: All nursing staff winserviced on the facility guidelines for hand was glove use during care, drainage bag and tubir placement, carrying treinto and out of rooms a cleaning of equipment after treatments. 4. However, the alleged of practice does not recurred to ensure the alleged of the practice does not recurred to ensure the alleged of the practice does not recurred to ensure the alleged of the practice does not recurred to ensure the alleged of the	shing, catheter and seatments in an and or to and seatments be affected efficient actions we the by this out into anges aged not the ch nursing was before and before and before and before and ow the emonitored deficient control: See during a bag and ents in and ing of after use	

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN46012 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Regulatory or LSC IDENTIFYING INFORMATION) TAG Rembers 5 times per week x4 weeks, , then 5 staff members monthly x 5 months to ensure			X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN46012 (X5) PREFIX (EACH CORRECTION GEACH CORRECTION FORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION INF	AND PLAN OF CORRECTION				A. BUILDING 00		COMPLETED		
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves 1707 BETHANY RD ANDERSON, IN46012 (X5) PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG members 5 times per week x4 weeks, , then 5 staff members monthly x 5 months to ensure		155698		B. WIN			00/30/201	I	
BETHANY POINTE HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves ANDERSON, IN46012 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG members 5 times per week x4 weeks, then 5 staff members monthly x 5 months to ensure	NAME OF PROVIDER OR SUPPLIER				1				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG members 5 times per week x4 weeks, , then 5 staff members monthly x 5 months to ensure	BETHANY POINTE HEALTH CAMPUS				1				
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG members 5 times per week x4 weeks, then 5 staff members monthly x 5 months to ensure								(V5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the resident's bed, she removed her gloves CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG members 5 times per week x4 weeks, then 5 staff members monthly x 5 months to ensure		(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) her chair. After CNA #1 made the				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
resident's bed, she removed her gloves weeks, , then 5 staff members monthly x 5 months to ensure						CROSS-REFERENCED TO THE APPROPRIAT	TE.		
resident's bed, she removed her gloves weeks, , then 5 staff members						members 5 times per week x	:4		
I I Monthly x 5 months to ensure I									
The first the first term of th							inen		
needed thereafter. The results of							Its of		
On 6/27/11 from 11:40 a.m. to 11:55 a.m., the audits will be reported,		On 6/27/11 from	11:40 a m to 11:55 a m			the audits will be reported,			
Posident #5.4's transfer was absented reviewed and trended for		1							
After the transfer from the resident's bed compliance thru the campus Quality Assurance Committee for		1					e for		
to her wheelchair was completed, LPN #3 a minimum of 6 months, then						-			
was observed to remover her gloves and randomly thereafter. The			_			randomly thereafter. The			
handwork for loss than 15 seconds			_						
completed on all 3 shifts.		indira washi tor tes	s than 10 seconds.			completed on all 3 shifts.			
During a care and transfer observation on		During a care and	d transfer observation on						
6/27/11 at 11:20 a.m., CNA # 14 and # 15		1 -							
entered resident # 60's room. They placed		1							
		a hoyer pad under the resident. CNA # 14 then placed the anchored catheter							
drainage bag and tubing on the resident's									
stomach in the bed. There was urine in		1 -	_						
the bag and tubing. The CNA asks the									
resident to hold onto the hook of the		1	_						
anchored catheter which she does. During									
the transfer the anchored catheter drainage		1							
bag and tubing remained on the resident's			_						
stomach above the level of the bladder.		1 "							
The resident had her hands on the									
anchored catheter bag and tubing. At the									
end of the observation, the Resident's		1							
hands were not washed.		1							
			·						
During a wound treatment observation on		During a wound	treatment observation on						
6/28/11 at 1:38 p.m., with LPN #18,		1							
Resident # 60 was in bed. The LPN		_							
entered the room and placed a towel on									

AND PLAN OF CORRECTION IDENTIFY		DENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
	155698		B. WING			06/30/2011	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			•	1707 BE	DDRESS, CITY, STATE, ZIP CODE ETHANY RD SON, IN46012	•	
				<u> </u>	30N, IN40012		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	DATE
		dressing supplies		_			
		e of wound cleanser,					
		ed silver antimicrobial					
	1	ssing supplies. She then					
	_	s and donned gloves.					
	She moved the towel to place it under the						
		ot. The dressing supplies					
		the residents bed at that					
	1	vounds were cleansed she					
	place the wound	cleanser on the sheet by					
	the resident's left	foot. She then took					
	scissors from her	jacket pocket and placed					
	them on the insid	le of the silver					
	antimicrobial dre	essing package. She then					
	cut the silver ant	imicrobial dressing to a					
	size to fit the wo	und and places it on the					
	abrasions on the	resident's left 2nd and					
	3rd toes. She the	en placed the scissors on					
	_	dressing. After dressing					
		he telfa, she picked up					
	1	placed them back in her					
	1	ted up the wound					
		nd the silver antimicrobial					
	• • •	and placed it on the					
		by the bathroom door so					
		ner hands. After exiting					
	· ·	18 placed the wound					
		silver antimicrobial					
	• • •	back into the treatment					
		e during interview, she					
		aned her scissors if she					
		off a soiled dressing.					
		d the wound cleanser and					
	silver dressing w	ere reusable.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WF4S11 Facility ID:

011045

If continuation sheet Page 62 of 63

l	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			E SURVEY PLETED /2011	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	Review of a facion 1/11, policy title Procedures Acknown was provided by on 6/29/11 at 8:4 following: "Objective: 1. To remove trafform HCW's [he Wash well for motion and friction and friction was policy to (Clean)", which Assistant Director at 10:15 a.m., incomplete the series of the seri	lity provided, current, ed "Handwashing nowledgement", which the Director of Nursing .5 a.m., indicated the ansient microorganisms alth care worker's] hands 20 seconds, using rotary on." lity provided current, itled, "Dressing Change was provided by the or of Nursing on 6/29/11 dicated the following: ld with paper towels or					

011045